

Transfer Checklist

Hospital Communications	
Date and Time:	
Patient Name/Age: DOB Identification Bracelet applied to _____ (location of band)	
Sex/ WT (in kg) Height in cm Head circumference if less than 2 years of age:	
Chief Complaint:	
Referring MD:	Accepting Facility: Accepting MD:
Consent:	
AMPLE History: A: Allergies M: Medications P: Past medical History L: last meal E: Events leading up to injury	
CHECKLIST	
<input type="checkbox"/> Working Diagnoses	
<input type="checkbox"/> Interventions/Treatments Thus far:	
<input type="checkbox"/> Physical Findings and Assessment:	
<input type="checkbox"/> Airway Assessment (circle any patient presenting symptoms)	Normal-breath sounds clear and equal Noisy breathing Retractions Drooling Tripoding Intubated _____ size, position
<input type="checkbox"/> Breathing (circle any patient presenting symptoms)	O2 requirement- Nasal cannula or mask ____L Increased WOB Altered LOC
<input type="checkbox"/> Circulation (circle any patient presenting symptoms)	Dysrhythmias Poor perfusion _____ Cap Refill _____sec Vascular Access- _____(site/size)
<input type="checkbox"/> Disability	GCS E: _____ V: _____ M: _____ = _____ Increased ICP (pupils, posturing) Seizure Activity Fontanels- soft____ bulging____ Non applicable ____
<input type="checkbox"/> Exposure (any precautions/isolation)	Rash Wounds Deformity
<input type="checkbox"/> Abnormal Lab findings	

<input type="checkbox"/> Radiological findings	
<input type="checkbox"/> Mode of transportation (to be matched with patient acuity and care needs during transport)	BLS ALS Specialty Team Air vs Ground Private Car
<input type="checkbox"/> Specialty equipment to accompany patient on transfer:	List all specialty equipment/supplies to accompany patient: i.e. blood products/medications/warming device
<input type="checkbox"/> Documentation accompanying patient	Medical Record Yes____ No____ Radiographic disk, films or copies Yes ____ No____ Lab Results Yes____ No____ Consent to transfer Yes____ No ____ Transfer Note Yes ____ No ____
<input type="checkbox"/> Parent Guardian Considerations	Consent to transfer obtained Yes ____No____ Plan for transfer of patient belongings Yes____ No ____ Referral institution information including directions and accepting physician name provided to family Yes ____ No____
<input type="checkbox"/> Vital signs prior to Departure including: Respiratory rate ____Heart rate ____ Blood Pressure ____ and Temperature____ Oxygen Sat____	
<input type="checkbox"/> Departure Time:	
Name and number of contact person if additional information needed: _____	
Transferring Nurse Signature:	
Transferring Physician Signature:	

Adaptation of tool from:
Golden Hour The Handbook of Advanced Pediatric Life Support
3rd edition, 2011
Nichols, Yaster, Scleien, Padias